

		FOR OHF USE					

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**2001**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2001)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0039768</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>																									
<b>Facility Name:</b> <u>Lexington of Lake Zurich</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/01</u> to <u>12/31/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
<b>Address:</b> <u>930 South Rand Road</u> <u>Lake Zurich</u> <u>60047</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
<b>County:</b> <u>Lake</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
<b>Telephone Number:</b> <u>( 847 ) 726-1200</u> <b>Fax #</b> <u>( 847 ) 726-1265</u>		<b>Paid Preparer</b> (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 634-3400</u> <b>Fax #</b> <u>(312) 634-5518</u>																									
<b>IDPA ID Number:</b> <u>363748801001</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>																									
<b>Date of Initial License for Current Owners:</b> <u>8/20/94</u>																											
<b>Type of Ownership:</b> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County		<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
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	<input checked="" type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
<b>IRS Exemption Code</b> _____																											
In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page																											

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich# 0039768 Report Period Beginning: 1/1/01 Ending: 12/31/01

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds 2/1/01

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>203</u>	Skilled (SNF)	<u>203</u>	<u>74,095</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>8</u>	Sheltered Care (SC)	<u>0</u>	<u>248</u>	5
6		ICF/DD 16 or Less			6
7	<u>211</u>	TOTALS	<u>203</u>	<u>74,343</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>18,061</u>	<u>2,842</u>	<u>6,635</u>	<u>27,538</u>	8
9	SNF/PED					9
10	ICF	<u>26,577</u>	<u>4,603</u>	<u>896</u>	<u>32,076</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>44,638</u>	<u>7,445</u>	<u>7,531</u>	<u>59,614</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 80.19%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been  
eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 8/20/94

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date New constructionNO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 35 and days of care provided 6,267Medicare Intermediary AdminaStar Federal

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED  
CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: 12/31/01

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning:

1/1/01

Ending:

12/31/01

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	277,859	35,831	9,563	323,253		323,253		323,253			1
2	Food Purchase		251,541		251,541		251,541	(11,025)	240,516			2
3	Housekeeping	251,101	31,249		282,350		282,350		282,350			3
4	Laundry	65,503	24,654		90,157		90,157	(4,154)	86,003			4
5	Heat and Other Utilities			198,716	198,716		198,716	2,908	201,624			5
6	Maintenance	69,901		124,788	194,689		194,689	1,669	196,358			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	664,364	343,275	333,067	1,340,706		1,340,706	(10,602)	1,330,104			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			19,100	19,100		19,100		19,100			9
10	Nursing and Medical Records	2,337,184	175,208	2,400	2,514,792		2,514,792		2,514,792			10
10a	Therapy			565,651	565,651		565,651		565,651			10a
11	Activities	149,535	26,327	5,135	180,997		180,997		180,997			11
12	Social Services	45,719		5,264	50,983		50,983		50,983			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	2,532,438	201,535	597,550	3,331,523		3,331,523		3,331,523			16
	<b>C. General Administration</b>											
17	Administrative	185,637		304,083	489,720		489,720	(304,083)	185,637			17
18	Directors Fees											18
19	Professional Services			34,911	34,911		34,911	3,195	38,106			19
20	Dues, Fees, Subscriptions & Promotions			108,309	108,309		108,309	2,383	110,692			20
21	Clerical & General Office Expenses	413,895	31,002	22,183	467,080		467,080	14,144	481,224			21
22	Employee Benefits & Payroll Taxes			460,491	460,491		460,491	53,285	513,776			22
23	Inservice Training & Education			950	950		950		950			23
24	Travel and Seminar			3,018	3,018		3,018	1,520	4,538			24
25	Other Admin. Staff Transportation			278	278		278	8,795	9,073			25
26	Insurance-Prop.Liab.Malpractice			120,374	120,374		120,374	2,166	122,540			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	599,532	31,002	1,054,597	1,685,131		1,685,131	(218,595)	1,466,536			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,796,334	575,812	1,985,214	6,357,360		6,357,360	(229,197)	6,128,163			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name & ID Number Lexington of Lake Zurich

#0039768

Report Period Beginning:

1/1/01

Ending:

12/31/01

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			32,667	32,667		32,667	218,919	251,586			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			87,000	87,000		87,000	327,298	414,298			32
33	Real Estate Taxes							130,819	130,819			33
34	Rent-Facility & Grounds			1,329,166	1,329,166		1,329,166	(1,329,166)				34
35	Rent-Equipment & Vehicles			564	564		564	598	1,162			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,449,397	1,449,397		1,449,397	(651,532)	797,865			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		128,915	51,539	180,454		180,454		180,454			39
40	Barber and Beauty Shops			24,993	24,993		24,993		24,993			40
41	Coffee and Gift Shops			5,729	5,729		5,729		5,729			41
42	Provider Participation Fee			111,143	111,143		111,143		111,143			42
43	Other (specify):* <b>Nonallowable costs</b>			8,677	8,677		8,677	(8,677)				43
44	<b>TOTAL Special Cost Centers</b>		128,915	202,081	330,996		330,996	(8,677)	322,319			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,796,334	704,727	3,636,692	8,137,753		8,137,753	(889,406)	7,248,347			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

\*\*See schedule of adjustments attached at end of cost report

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning:

1/1/01

Ending:

12/31/01

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(201)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(4,154)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(8,646)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(831)	43		13
14	Non-Care Related Interest	(78,354)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,634)	43		24
25	Fund Raising, Advertising and Promotional	(7,712)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	1,509	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(8,885)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (108,908)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(780,498)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (780,498)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (889,406)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington of Lake Zurich**  
**Provider # 0039768**  
**1/1/01 - 12/31/01**

**Schedule A**

Schedule VI. Adjustment detail  
Line 29, Other

Description	Amount	Reference
Nonallowable collections	(3,092)	19
Out of period legal fees	(497)	19
Nonallowable Chamber of Commerce dues	(610)	20
Deferred maintenance amort.	701	6
Offset miscellaneous income	(5,387)	21
Total	<u>(8,885)</u>	

**See Accountants' Compilation Report**

Lexington of Lake Zurich

ID# 0039768

Report Period Beginning: 1/1/01

Ending: 12/31/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
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24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning:

1/1/01

Ending:

12/31/01

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(201)	0	0	0	0	0	0	0	0	0	0	(201)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(4,154)	0	0	0	0	0	0	0	0	0	0	(4,154)	4
5	Heat and Other Utilities	0	0	2,908	0	0	0	0	0	0	0	0	2,908	5
6	Maintenance	0	0	968	0	0	0	0	0	0	0	0	968	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(4,355)</b>	<b>0</b>	<b>3,876</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(479)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	(304,083)	0	0	0	0	0	0	0	(304,083)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	50	6,734	0	0	0	0	0	0	0	0	6,784	19
20	Fees, Subscriptions & Promotions	0	0	2,993	0	0	0	0	0	0	0	0	2,993	20
21	Clerical & General Office Expenses	0	74	19,457	0	0	0	0	0	0	0	0	19,531	21
22	Employee Benefits & Payroll Taxes	0	0	42,461	0	0	0	0	0	0	0	0	42,461	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,520	0	0	0	0	0	0	0	0	1,520	24
25	Other Admin. Staff Transportation	0	0	8,795	0	0	0	0	0	0	0	0	8,795	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	2,166	0	0	0	0	0	0	0	2,166	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>0</b>	<b>124</b>	<b>81,960</b>	<b>(301,917)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(219,833)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(4,355)</b>	<b>124</b>	<b>85,836</b>	<b>(301,917)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(220,312)</b>	<b>29</b>



## Summary B

12/31/01

[illegible]

Facility Name & ID Number Lexington of Lake Zurich# 0039768

Report Period Beginning:

1/1/01

Ending:

12/31/01

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas	33.33%			Lexington Health Care Systems of		
John Samatas	33.33%	See attached Schedule B		Lake Zurich Ltd Ptsp	Lake Zurich	Real estate ptsp.
Cynthia Thiem	33.34%			Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services, L.L.C. II	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental expense	\$ 1,329,166	Lexington Health Care Systems of Lake Zurich Ltd Ptsp		\$	\$ (1,329,166)	1
2	V	19 Professional fees		Lexington Health Care Systems of Lake Zurich Ltd Ptsp		50	50	2
3	V	21 Bank charges		Lexington Health Care Systems of Lake Zurich Ltd Ptsp		74	74	3
4	V	30 Depreciation		Lexington Health Care Systems of Lake Zurich Ltd Ptsp		206,988	206,988	4
5	V	32 Interest expense		Lexington Health Care Systems of Lake Zurich Ltd Ptsp		409,550	409,550	5
6	V	32 Amortization of mortgage costs		Lexington Health Care Systems of Lake Zurich Ltd Ptsp		3,577	3,577	6
7	V	33 Property taxes		Lexington Health Care Systems of Lake Zurich Ltd Ptsp		129,166	129,166	7
8	V	43 State replacement tax	9	Lexington Health Care Systems of Lake Zurich Ltd Ptsp			(9)	8
9	V			Lexington Health Care Systems of Lake Zurich Ltd Ptsp				9
10	V							10
11	V			** The owners of Lexington Health Care Center of Lake Zurich, Inc. own 100% of Lexington				11
12	V			Health Care Systems of Lake Zurich Limited Partnership.				12
13	V							13
14	Total		\$ 1,329,175			\$ 749,405	\$ * (579,770)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning: 1/1/01

Ending: 12/31/01

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 Utilities - gas & electric	\$	Royal Management Corp.	**	\$ 2,572	\$ 2,572 15
16	V	5 Utilities - water & sewer		Royal Management Corp.	**	336	336 16
17	V	6 Repairs & maintenance		Royal Management Corp.	**	674	674 17
18	V	6 Scavenger & exterminating		Royal Management Corp.	**	282	282 18
19	V	6 Security service		Royal Management Corp.	**	12	12 19
20	V	19 Computer consultant & supplies		Royal Management Corp.	**	5,149	5,149 20
21	V	19 Professional fees		Royal Management Corp.	**	1,585	1,585 21
22	V	20 Advertising - help wanted		Royal Management Corp.	**	2,449	2,449 22
23	V	20 Dues & subscriptions		Royal Management Corp.	**	544	544 23
24	V	21 Bank charges		Royal Management Corp.	**	2,934	2,934 24
25	V	21 Communications		Royal Management Corp.	**	530	530 25
26	V	21 Office supplies & printing		Royal Management Corp.	**	6,328	6,328 26
27	V	21 Postage		Royal Management Corp.	**	2,672	2,672 27
28	V	21 Telephone		Royal Management Corp.	**	6,993	6,993 28
29	V	22 FICA		Royal Management Corp.	**	26,048	26,048 29
30	V	22 FUTA		Royal Management Corp.	**	537	537 30
31	V	22 SUTA		Royal Management Corp.	**	1,018	1,018 31
32	V	22 Insurance - W/C		Royal Management Corp.	**	328	328 32
33	V	22 Insurance - Hospitalization		Royal Management Corp.	**	10,877	10,877 33
34	V	22 401(k) and other emp. benefits		Royal Management Corp.	**	3,653	3,653 34
35	V	24 Travel & seminar		Royal Management Corp.	**	1,520	1,520 35
36	V	25 Auto expense		Royal Management Corp.	**	8,795	8,795 36
37	V						37
38	V	** Certain owners of Lexington Health Care Center of Lake Zurich, Inc. own 100% of Royal Management Corp.					38
39	Total		\$			\$ 85,836	\$ * 85,836 39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning: 1/1/01

Ending: 12/31/01

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	26 Insurance - general	\$	Royal Management Corp.	**	\$ 2,166	\$ 2,166	15
16	V	30 Depreciation - vehicles		Royal Management Corp.	**	3,661	3,661	16
17	V	30 Depreciation - leasehold improv.		Royal Management Corp.	**	2,254	2,254	17
18	V	30 Depreciation - equipment		Royal Management Corp.	**	6,016	6,016	18
19	V	32 Interest		Royal Management Corp.	**	1,171	1,171	19
20	V	33 Property taxes		Royal Management Corp.	**	1,653	1,653	20
21	V	35 Equipment rental		Royal Management Corp.	**	598	598	21
22	V	17 Management	304,083	Royal Management Corp.	**		(304,083)	22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V	** Certain owners of Lexington Health Care Center of Lake Zurich, Inc. own 100% of Royal Management Corp.						38
39	Total		\$ 304,083			\$ 17,519	\$ * (286,564)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington of Lake Zurich**  
**Provider # 0039768**  
**1/1/01 - 12/31/01**

**Schedule B**

VII. Related Parties  
Related Nursing Homes

Name of facility

City

Lexington Health Care Center of Lombard, Inc.  
Lexington Health Care Center of Bloomingdale, Inc.  
Lexington Health Care Center of Chicago Ridge, Inc.  
Lexington Health Care Center of Elmhurst, Inc.  
Lexington Health Care Center of LaGrange, Inc.  
Lexington Health Care Center of Schaumburg, Inc.  
Lexington Health Care Center of Streamwood, Inc.  
Lexington Health Care Center of Wheeling, Inc.  
Lexington Health Care Center of Orland Park, Inc.

Lombard  
Bloomingdale  
Chicago Ridge  
Elmhurst  
LaGrange  
Schaumburg  
Streamwood  
Wheeling  
Orland Park

**See Accountants' Compilation Report**

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number      Lexington of Lake Zurich      #      0039768      Report Period Beginning:      1/1/01      Ending:      12/31/01

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	33.33%	See Schedule C	4	8.00%	Salary	\$ 36,664	L17, C1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	33.33%	See Schedule C	2	4.00%	Salary	16,123	L17, C1	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34%	See Schedule C	2	4.00%	Salary	20,230	L17, C1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	4.00%	Salary	8,260	L17, C1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	6	12.00%	Salary	11,148	L17, C1	5
6											6
7						All individuals work in excess of 40 hours per week.					7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 92,425		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington of Lake Zurich**

**Provider # 0039768**

**1/1/01 - 12/31/01**

**Schedule C**

**VII. Related Parties**

**C. Statement of Compensation and Other Payments to Owners, Relatives  
and Members of the Board of Directors**

**5. Compensation Received From Other Nursing Homes**

<u>Name of facility</u>	<u>John Samatas</u>	<u>James Samatas</u>	<u>Cynthia Thiem</u>	<u>George Samatas</u>	<u>Jason Samatas</u>	<u>Total</u>
Lexington Health Care Center of Bloomingdale, Inc.	13,615	30,961	17,085	6,975	9,414	78,050
Lexington Health Care Center of Chicago Ridge, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Elmhurst, Inc.	11,728	26,672	14,718	6,009	8,110	67,237
Lexington Health Care Center of LaGrange, Inc.	8,628	19,621	10,827	4,420	5,966	49,462
Lexington Health Care Center of Lombard, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Orland Park, Inc.	20,900	47,523	26,222	10,707	14,447	119,799
Lexington Health Care Center of Schaumburg, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Streamwood, Inc.	17,732	40,322	22,250	9,084	12,260	101,648
Lexington Health Care Center of Wheeling, Inc.	17,495	39,783	21,953	8,961	12,097	100,289
Seneca Nursing Home, Inc. d/b/a Lee Manor Nursing Residence	3,608	8,205	4,528	1,849	2,495	20,685
Total	146,902	334,053	184,333	75,257	101,569	842,114

**See Accountants' Compilation Report**

Facility Name & ID Number Lexington of Lake Zurich# 0039768

Report Period Beginning:

1/1/01Ending: 12/31/01

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Royal Management Corp.Street Address 665 W. North Avenue, Suite 500City / State / Zip Code Lombard, IL 60148Phone Number ( 630 ) 458-4700Fax Number ( 630 ) 458-4796

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities - gas & electric	Bed Days	751,703	11	\$ 26,007	\$ 74,343	\$ 2,572	1
2	5	Utilities - water & sewer	Bed Days	751,703	11	3,397	74,343	336	2
3	6	Repairs & maintenance	Bed Days	751,703	11	6,818	74,343	674	3
4	6	Scavenger & exterminating	Bed Days	751,703	11	2,851	74,343	282	4
5	6	Security Service	Bed Days	751,703	11	125	74,343	12	5
6	19	Computer consultant & supplies	Bed Days	751,703	11	52,068	74,343	5,149	6
7	19	Professional fees	Bed Days	751,703	11	16,027	74,343	1,585	7
8	20	Advertising - help wanted	Bed Days	751,703	11	24,766	74,343	2,449	8
9	20	Dues & subscriptions	Bed Days	751,703	11	5,496	74,343	544	9
10	21	Bank charges	Bed Days	751,703	11	29,664	74,343	2,934	10
11	21	Communications	Bed Days	751,703	11	5,359	74,343	530	11
12	21	Office supplies & printing	Bed Days	751,703	11	63,988	74,343	6,328	12
13	21	Postage	Bed Days	751,703	11	27,021	74,343	2,672	13
14	21	Telephone	Bed Days	751,703	11	70,716	74,343	6,993	14
15	22	FICA	Bed Days	751,703	11	263,374	74,343	26,048	15
16	22	FUTA	Bed Days	751,703	11	5,433	74,343	537	16
17	22	SUTA	Bed Days	751,703	11	10,292	74,343	1,018	17
18	22	Insurance - W/C	Bed Days	751,703	11	3,319	74,343	328	18
19	22	Insurance - Hospitalization	Bed Days	751,703	11	109,982	74,343	10,877	19
20	22	401(k) and other emp. benefits	Bed Days	751,703	11	36,931	74,343	3,653	20
21	24	Travel & seminar	Bed Days	751,703	11	15,373	74,343	1,520	21
22	25	Auto expense	Bed Days	751,703	11	88,927	74,343	8,795	22
23									23
24									24
25	TOTALS				\$ 867,934	\$		\$ 85,836	25

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Lexington of Lake Zurich# 0039768

Report Period Beginning:

1/1/01Ending: 12/31/01

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Royal Management Corp.Street Address 665 W. North Avenue, Suite 500City / State / Zip Code Lombard, IL 60148Phone Number ( 630 ) 458-4700Fax Number ( 630 ) 458-4796

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26 Insurance - general	Bed Days	751,703	11	\$ 21,896	\$	74,343	\$ 2,166	1
2	30 Depreciation - vehicles	Bed Days	751,703	11	37,022		74,343	3,661	2
3	30 Depreciation - leasehold improv.	Bed Days	751,703	11	22,789		74,343	2,254	3
4	30 Depreciation - equipment	Bed Days	751,703	11	60,826		74,343	6,016	4
5	32 Interest	Bed Days	751,703	11	11,844		74,343	1,171	5
6	33 Property taxes	Bed Days	751,703	11	16,719		74,343	1,653	6
7	35 Equipment rental	Bed Days	751,703	11	6,049		74,343	598	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 177,145	\$		\$ 17,519	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Lexington Financial						\$					\$	1
2	Services, L.L.C. II	X		Mortgage	\$49,259	12/29/98		6,478,000	5,983,706	12/29/08	0.0675	409,553	2
3													3
4													4
5													5
	Working Capital												
6	Shareholders	X		Working Capital	None	Varies		27,033	1,628,944	Demand	0.0500	87,000	6
7													7
8													8
9	TOTAL Facility Related				\$49,259.00		\$	6,505,033	\$ 7,612,650			\$ 496,553	9
	B. Non-Facility Related*												
10									Amortization of loan costs			3,577	10
11									Interest income offset			(8,649)	11
12									Non-allowable interest			(78,354)	12
13									Allocated from management company			1,171	13
14	TOTAL Non-Facility Related						\$					\$ (82,255)	14
15	TOTALS (line 9+line14)						\$	6,505,033	\$ 7,612,650			\$ 414,298	15

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Lexington of Lake Zurich**# **0039768**

Report Period Beginning:

**1/1/01**

Ending:

**12/31/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.			\$	<b>117,000</b>	1
		Allocated from management company		<b>1,653</b>	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2000	\$	<b>120,166</b>		2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>4,819</b>		3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>126,000</b>		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>130,819</b>		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1996	<b>100,962</b>	8		
	1997	<b>109,668</b>	9		
	1998	<b>111,454</b>	10		
	1999	<b>112,784</b>	11		
	2000	<b>120,166</b>	12		
<b>2000 taxes:</b>	<b>120,166.00</b>				
<b>Estimated increase (4.5%)</b>	<b>1.05</b>				
<b>Estimated 2001 taxes:</b>	<b>125,573.00</b>				
<b>Use:</b>	<b>126,000.00</b>				
				<b>FOR OHF USE ONLY</b>	
		13	FROM R. E. TAX STATEMENT FOR 2000	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Lexington of Lake Zurich COUNTY Lake

FACILITY IDPH LICENSE NUMBER 0039768

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE ( 630 ) 458-4700 FAX #: ( 630 ) 458-4795

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-28-100-020</u>	<u>Land and building</u>	\$ <u>120,165.52</u>	\$ <u>120,165.52</u>
2. <u>Royal Management Corp. (Omni Partners)</u>		\$ _____	\$ _____
3. <u>06-19-201-018</u>	<u>Land and building</u>	\$ <u>68,214.22</u>	\$ <u>1,653.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>188,379.74</u>	\$ <u>121,818.52</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES   x   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A.
Square Feet:
78,901

B. General Construction Type:

Exterior
Brick

Frame
Steel

Number of Stories
3

C.
Does the Operating Entity?

☐ (a) Own the Facility
☒ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.
Does the Operating Entity?

☒ (a) Own the Equipment
☒ (b) Rent equipment from a Related Organization.
☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F.
Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
☒ NO

If so, please complete the following:

1. Total Amount Incurred:
N/A

2. Number of Years Over Which it is Being Amortized:
N/A

3. Current Period Amortization:
N/A

4. Dates Incurred:
N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	250,344	1990	\$ 495,000	1
2					2
3	TOTALS	250,344		\$ 495,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 12

Facility Name &amp; ID Number Lexington of Lake Zurich

# 0039768

Report Period Beginning:

1/1/01

Ending:

12/31/01

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	203	1994	1994	\$ 6,418,908	\$	40	\$ 160,473	\$ 160,473	\$ 1,176,800
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Land Improvements	1994		10,701		10	1,070	1,070	8,026
10	Land Improvements	1994		13,329	1,333	10	1,333		9,997
11	Leasehold Improvements	1994		4,737	316	15	316		2,369
12	Leasehold Improvements	1995		4,005	267	15	267		1,736
13	Land Improvements	1995		3,221		10	323	323	2,094
14	Building Improvements	1995		3,019		40	75	75	491
15	Building Improvements	1995		64,500	1,654	39	1,654		11,096
16	Patio	1996		1,168	78	15	78		428
17	Compressor	1996		5,145	514	10	514		2,829
18	Road sidewalk	1997		18,094		20	905	905	4,071
19	Foundation/Sprinkler	1997		2,068	59	35	59		266
20	Flagpoles	1997		1,573	105	15	105		472
21	Basement rehab	1998		12,867	1,287	10	1,287		4,504
22	MDS Telnet wiring	1998		3,365	337	10	337		1,178
23	Flag Pole	1998		787	52	15	52		184
24	Resurface/restripe parking lot	1998		4,976	498	10	498		1,742
25	Transfer 10 beds from shelter care	1998		2,259	56	40	56		179
26	1st floor lobby tile	1999		12,153	1,216	10	1,216		3,038
27	Parking lot repair	2000		3,740	374	10	374		561
28	Roof repair	2000		10,770	1,077	10	1,077		1,616
29	Automatic door	2000		1,300	130	10	130		195
30	Kitchen rehab	2000		16,887	1,689	10	1,689		2,533
31	Compressor	2001		4,350	217	10	217		217
32	Boiler vent	2001		3,228	161	10	161		161
33	Fire pump	2001		1,766	88	10	88		88
34	Kitchen rehab	2001		721	36	10	36		36
35	Elevator infrared curtains	2001		4,500	225	10	225		10
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Allocated from management company	1995	\$ 9,932	\$		\$ 308	\$ 308	\$ 1,845	37
38 Allocated from management company	1996	8,083			250	250	1,270	38
39 Allocated from management company	1989	279			9	9	122	39
40 Allocated from management company - HVAC	1998	209			6	6	24	40
41 Allocated from management company - offices	1999	528			16	16	38	41
42 Allocated from management company - offices	2000	251			8	8	12	42
43 Allocated from management company	1987	51,108			1,583	1,583	22,383	43
44 Allocated from management company	1993	27			1	1	6	44
45 Allocated from management company	1995	1,151			36	36	191	45
46 Allocated from management company	1996	231			7	7	31	46
47 Allocated from management company - Sidewalk	1998	481			15	15	42	47
48 Allocated from management company - Roof	1998	18			1	1	5	48
49 Allocated from management company - Awnings	1999	136			4	4	9	49
50 Allocated from management company - Parking lot	1999	297			9	9	69	50
51 Allocated from management company - Facade	2001	42			1	1	1	51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 6,706,910	\$ 11,769		\$ 176,869	\$ 165,100	\$ 1,262,965	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 582,468	\$ 20,135	\$ 64,277	\$ 44,142	5-10 years	\$ 386,290	71
72	Current Year Purchases	7,627	763	763		5	763	72
73	Fully Depreciated Assets	3,853					3,853	73
74	Allocated from management company	64,983		6,016	6,016		47,216	74
75	TOTALS	\$ 658,931	\$ 20,898	\$ 71,056	\$ 50,158		\$ 438,122	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79	Allocated from management company			29,417		3,661	3,661		19,163	79
80	TOTALS			\$ 29,417	\$	\$ 3,661	\$ 3,661		\$ 19,163	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,890,258	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 32,667	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 251,586	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 218,919	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,720,250	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT



## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease                     .

9. Option to Buy: ☐ YES ☐ NO Terms:                                     \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 1,162

Description: Copier: \$564; Allocation from management company: \$598

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning                     

Ending                     

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.                      /2002 \$                     

13.                      /2003 \$                     

14.                      /2004 \$                     

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	14,664	\$ 191,729	\$	14,664	\$ 191,729	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		3,388	51,162		3,388	51,162	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		31,698	322,760		31,698	322,760	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				128,915		128,915	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See attached Schedule D					51,539			51,539	13
14	TOTAL			\$	49,750	\$ 617,190	\$ 128,915	49,750	\$ 746,105	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington of Lake Zurich**

**Provider # 0039768**

**1/1/01 - 12/31/01**

**Schedule D**

XIV. Special Services (Direct Cost)

Line 13, Other

Service	Cost	Line Reference
Oxygen	7,759	L 39, C3
Laboratory	2,497	L 39, C3
Radiology	2,155	L 39, C3
Dentist	319	L 39, C3
Clinitron beds	38,809	L 39, C3
Total	<u>51,539</u>	

**See Accountants' Compilation Report**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 77,787	\$ 22,889	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 250,000 )	1,421,037	1,421,037	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,723	40,723	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	10,924	10,924	8
9	Other(specify): Escrows		28,196	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,550,471	\$ 1,523,769	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,070	7,070	12
13	Land		495,000	13
14	Buildings, at Historical Cost		6,418,908	14
15	Leasehold Improvements, at Historical Cost	180,195	288,002	15
16	Equipment, at Historical Cost	152,519	688,348	16
17	Accumulated Depreciation (book methods)	(108,202)	(1,720,250)	17
18	Deferred Charges		1,052	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized mortgage costs		60,817	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 231,582	\$ 6,238,947	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,782,053	\$ 7,762,716	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 271,921	\$ 271,921	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,628,944	1,628,944	29
30	Accrued Salaries Payable	146,411	146,411	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,883	2,883	31
32	Accrued Real Estate Taxes(Sch.IX-B)		126,000	32
33	Accrued Interest Payable		33,658	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See attached Schedule E	553,399	115,612	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 2,603,558	\$ 2,325,429	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,983,706	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 5,983,706	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,603,558	\$ 8,309,135	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (821,505)	\$ (546,419)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,782,053	\$ 7,762,716	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Lexington of Lake Zurich  
Provider # 0039768  
1/1/01 - 12/31/01

**Schedule E**

XV. Balance Sheet

C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Accrued Rent	437,787	-
Accrued management fees	59,048	59,048
Accrued 401 (k) contribution	13,544	13,544
401 (k) withholding	4,042	4,042
Other accrued expenses	35,054	35,054
Due to related parties	<u>3,924</u>	<u>3,924</u>
Total line 36	<u><u>553,399</u></u>	<u><u>115,612</u></u>

XVII. Income Statement

E. Other Revenue

28. Other Revenue

<u>Description</u>	<u>Amount</u>
Investment Income	1,813
Miscellaneous Income	5,387
Total line 28	<u><u>7,200</u></u>

**See Accountants' Compilation Report**

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ (1,169,052)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior year post closing entries</b>	<b>(87,888)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ (1,256,940)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>435,435</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 435,435</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (821,505)</b>	<b>24 *</b>

Operating entity only

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 7,836,444	1
2	Discounts and Allowances for all Levels	(576,065)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,260,379	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	986,813	6
7	Oxygen	588	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 987,401	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	12,216	12
13	Barber and Beauty Care	29,888	13
14	Non-Patient Meals	201	14
15	Telephone, Television and Radio	267	15
16	Rental of Facility Space		16
17	Sale of Drugs	171,221	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,049	19
20	Radiology and X-Ray	2,402	20
21	Other Medical Services	73,164	21
22	Laundry	4,154	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 309,562	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	8,646	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 8,646	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See attached Schedule E	7,200	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 7,200	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,573,188	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,340,706	31
32	Health Care	3,331,523	32
33	General Administration	1,685,131	33
	<b>B. Capital Expense</b>		
34	Ownership	1,449,397	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	219,853	35
36	Provider Participation Fee	111,143	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,137,753	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	435,435	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 435,435	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.  
This entity files a cash basis tax return.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



Facility Name & ID Number Lexington of Lake Zurich# 0039768Report Period Beginning: 1/1/01Ending: 12/31/01

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,861	2,016	\$ 97,523	\$ 48.37	1
2	Assistant Director of Nursing	3,609	3,783	98,729	26.10	2
3	Registered Nurses	38,349	40,945	938,202	22.91	3
4	Licensed Practical Nurses	15,220	15,976	331,238	20.73	4
5	Nurse Aides & Orderlies	73,266	75,365	819,616	10.88	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,799	4,083	51,876	12.71	8
9	Activity Director	1,471	1,529	18,164	11.88	9
10	Activity Assistants	14,871	15,463	131,371	8.50	10
11	Social Service Workers	2,575	2,575	45,719	17.75	11
12	Dietician	103	110	3,062	27.84	12
13	Food Service Supervisor					13
14	Head Cook	1,958	1,996	20,246	10.14	14
15	Cook Helpers/Assistants	17,550	18,385	158,695	8.63	15
16	Dishwashers	15,125	15,753	95,856	6.08	16
17	Maintenance Workers	4,109	4,419	69,901	15.82	17
18	Housekeepers	36,668	38,378	251,101	6.54	18
19	Laundry	10,322	10,875	65,503	6.02	19
20	Administrator	2,017	2,098	93,212	44.43	20
21	Assistant Administrator					21
22	Other Administrative	662	678	92,425	136.32	22
23	Office Manager					23
24	Clerical	25,638	27,038	413,895	15.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	269,173	281,465	\$ 3,796,334 *	\$ 13.49	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 9,563	L1, C3	35
36	Medical Director	Monthly	19,100	L9, C3	36
37	Medical Records Consultant	14	700	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	5,135	L11, C3	44
45	Social Service Consultant	Monthly	5,264	L11, C3	45
46	Other(specify)				46
47	Utilization Review	Monthly	500	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	14	\$ 41,462		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description		Amount	Description		Amount		
Connie Sherman	Administrator	0.00%	\$ 93,212	Workers' Compensation Insurance		\$ 39,094	IDPH License Fee		\$ 200		
John Samatas	Administrative	33.33%	16,123	Unemployment Compensation Insurance		23,595	Advertising: Employee Recruitment		105,023		
James Samatas	Administrative	33.33%	36,664	FICA Taxes		277,460	Health Care Worker Background Check (Indicate # of checks performed <u>84</u> )		1,014		
Cynthia Thiem	Administrative	33.34%	20,230	Employee Health Insurance		74,108	Miscellaneous Licenses & Permits		820		
George Samatas	Administrative	0.00%	8,260	Employee Meals		10,824	Miscellaneous Dues & Subs		642		
Jason Samatas	Administrative	0.00%	11,148	Illinois Municipal Retirement Fund (IMRF)*							
				401(k) Contribution		15,872					
				CNA Transportation		64,520					
				Other employee benefits		8,303					

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*See instructions.**

**Lexington of Lake Zurich**  
**Provider # 0039768**  
**1/1/01 - 12/31/01**

**Schedule F**

XIX. Support Schedules  
C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Advanced Information Management	Computer Services	2,984
Information Controls Inc.	Computer Services	1,218
		<u>4,202</u>
 Total, Agrees to Schedule V, Line 19, Column 3		 <u><u>34,911</u></u>
 Allocated from management co.		
Altschuler, Melvoin & Glasser, LLP/		
American Express Tax & Business Services	Accounting	1,026
James Samatas	Filing and recording fees	4
Sachnoff & Weaver	Legal	51
BDO Seidman LLP	Accounting	15
Robert Stachura	Accounting	2
Pension Administrators	401 (k) Administration	217
Various	Consulting	270
Various	Computer Services	5,149
 Allocated from building partnership		
James Samatas	Filing and recording fees	50
 Nonallowable legal fees		
Sachnoff & Weaver	Out of period legal fees	(497)
Freedman, Anselmo, & Lindberg	Legal-collection fees	(3,092)
 Total, Agrees to Schedule V, Line 19, Column 8		 <u><u>38,106</u></u>

**See accountants' compilation report.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Deferred maintenance	9/00	\$ 2,103	3	\$	\$	\$ 350	\$ 701	\$ 701	\$ 351	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 2,103		\$	\$	\$ 350	\$ 701	\$ 701	\$ 351	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Lake Zurich

STATE OF ILLINOIS

# 0039768

Report Period Beginning:

1/1/01

Ending:

Page 23

12/31/01

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 44,429 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 111,143  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 10,824 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 201
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0%  
d. Have vehicle usage logs been maintained? Adequate records are maintained  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Adjusted Total
1. Dietary	277,859	35,831	9,563	323,253	0	323,253	0	323,253
2. Food Pr	0	251,541	0	251,541	0	251,541	-11,025	240,516
3. Housek	251,101	31,249	0	282,350	0	282,350	0	282,350
4. Laundry	65,503	24,654	0	90,157	0	90,157	-4,154	86,003
5. Heat an	0	0	198,716	198,716	0	198,716	2,908	201,624
6. Mainten	69,901	0	124,788	194,689	0	194,689	1,669	196,358
7. Other (s	0	0	0	0	0	0	0	0
8. Total Gr	664,364	343,275	333,067	1,340,706	0	1,340,706	-10,602	1,330,104
9. Medical	0	0	19,100	19,100	0	19,100	0	19,100
10. Nursin	2,337,184	175,208	2,400	2,514,792	0	2,514,792	0	2,514,792
10a. Ther:	0	0	565,651	565,651	0	565,651	0	565,651
11. Activiti	149,535	26,327	5,135	180,997	0	180,997	0	180,997
12. Social	45,719	0	5,264	50,983	0	50,983	0	50,983
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	2,532,438	201,535	597,550	3,331,523	0	3,331,523	0	3,331,523
17. Admin	185,637	0	304,083	489,720	0	489,720	-304,083	185,637
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	34,911	34,911	0	34,911	3,195	38,106
20. Fees,	0	0	108,309	108,309	0	108,309	2,383	110,692
21. Clerics	413,895	31,002	22,183	467,080	0	467,080	14,144	481,224
22. Emplo	0	0	460,491	460,491	0	460,491	53,285	513,776
23. Inservi	0	0	950	950	0	950	0	950
24. Travel	0	0	3,018	3,018	0	3,018	1,520	4,538
25. Other .	0	0	278	278	0	278	8,795	9,073
26. Insura	0	0	120,374	120,374	0	120,374	2,166	122,540
27. Other	0	0	0	0	0	0	0	0
28. Total C	599,532	31,002	1,054,597	1,685,131	0	1,685,131	-218,595	1,466,536
29. Total C	3,796,334	575,812	1,985,214	6,357,360	0	6,357,360	-229,197	6,128,163
30. Depreci	0	0	32,667	32,667	0	32,667	218,919	251,586
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	87,000	87,000	0	87,000	327,298	414,298
33. Real E	0	0	0	0	0	0	130,819	130,819
34. Rent -	0	0	1,329,166	1,329,166	0	1,329,166	#####	0
35. Rent -	0	0	564	564	0	564	598	1,162
36. Other	0	0	0	0	0	0	0	0
37. Total C	0	0	1,449,397	1,449,397	0	1,449,397	-651,532	797,865
38. Medic:	0	0	0	0	0	0	0	0
39. Ancilla	0	128,915	51,539	180,454	0	180,454	0	180,454
40. Barber	0	0	24,993	24,993	0	24,993	0	24,993
41. Coffee	0	0	5,729	5,729	0	5,729	0	5,729
42. Provid	0	0	111,143	111,143	0	111,143	0	111,143
43. Other	0	0	8,677	8,677	0	8,677	-8,677	0
44. Total S	0	128,915	202,081	330,996	0	330,996	-8,677	322,319
45. Grand	3,796,334	704,727	3,636,692	8,137,753	0	8,137,753	-889,406	7,248,347

	After	Consolidation
General Service Cost Center		
1. Cash on	77,787	22,889
2. Cash - F	0	0
3. Account	1,421,037	1,421,037
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	40,723	40,723
7. Other Pr	0	0
8. Account	10,924	10,924
9. Other (s	0	28,196
10. Total ci	1,550,471	1,523,769
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	7,070	7,070
13. Land	0	495,000
14. Buildin	0	6,418,908
15. Lease	180,195	288,002
16. Equipm	152,519	688,348
17. Accum	-108,202	#####
18. Deferre	0	1,052
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other L	0	0
23. other (s	0	60,817
24. Total L	231,582	6,238,947
25. Total A	1,782,053	7,762,716
CURRENT LIABILITIES		
26. Accour	271,921	271,921
27. Officer'	0	0
28. Accour	0	0
29. Short-T	1,628,944	1,628,944
30. Accrue	146,411	146,411
31. Accrue	2,883	2,883
32. Accrue	0	126,000
33. Accrue	0	33,658
34. Deferre	0	0
35. Federa	0	0
36. Other C	553,399	115,612
37. Other C	0	0
38. Total C	2,603,558	2,325,429
LONG TERM LIABILITES		
39.Long-Te	0	0
40.Mortgaç	0	5,983,706
41.Bonds F	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lc	0	5,983,706
46.Total Li:	2,603,558	8,309,135
47.Total Ec	-821,505	-546,419
48.Total Li:	1,782,053	7,762,716

Balance per  
Medicaid  
Trial Balance

1. Gross F 7,836,444  
2. Discour -576,065

Subtota 7,260,379  
4. Day Ca 0  
5. Other C 0  
6. Therap 986,813  
7. Oxygen 588

Subtota 987,401  
9. Paymer 0  
10. Other 0  
11. Nurse 0  
12. Gift an 12,216  
13. Barber 29,888  
14. Non-P 201  
15. Teleph 267  
16. Rental 0  
17. Sale o 171,221  
18. Sale o 0  
19. Labor 16,049  
20. Radiol 2,402  
21. Other 73,164  
22. Laund 4,154

Subtot 309,562  
24. Contril 0  
25. Interest 8,646

Subtot 8,646  
27. Other 7,200  
28. Other 0  
Subtot 7,200

30. Total F 8,573,188  
31. Gener 1,340,706  
32. Health 3,331,523  
33. Gener 1,685,131  
34. Owner 1,449,397  
35. Specie 219,853  
35. Provid 111,143  
37. Other 0  
40. Total F 8,137,753  
41. Incom 435,435  
42. Incom 0  
43. Net In 435,435



Page

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10 Attachment of Real Estate Bill and fill out form

11

12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached

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19 The bottom right side of page under \*\*, you must write in any comments

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## RECONCILIATION REPORT

Lexington of Lake Zurich

03:15 PM

11/07/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-889,406	equal to	-889,406	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	414,298	equal to	414,298	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	130,819	equal to	130,819	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	251,586	equal to	251,586	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	1,162	equal to	1,162	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	565,651	equal to	565,651	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	128,915	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,340,706	equal to	1,340,706	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	3,331,523	equal to	3,331,523	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,685,131	equal to	1,685,131	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	1,449,397	equal to	1,449,397	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	219,853	equal to	219,853	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+	N/A	38to41+43	4
Income Stat. Prov. Partic.	111,143	equal to	111,143	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,285,308	equal to	2,337,184	-51,876	FAILED	Pg20 K11..K15+	A.	1-5;24;25;27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	149,535	equal to	149,535	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	45,719	equal to	45,719	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	277,859	equal to	277,859	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	69,901	equal to	69,901	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	251,101	equal to	251,101	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	65,503	equal to	65,503	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	185,637	equal to	185,637	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	413,895	equal to	413,895	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	3,796,334	equal to	3,796,334	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	9,563	< or = to	9,563	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	19,100	< or = to	19,100	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,900	< or = to	2,400	-500	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	5,135	< or = to	5,135	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	5,264	< or = to	5,264	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	185,637	equal to	185,637	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	304,083	equal to	304,083	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	34,911	equal to	34,911	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	513,776	equal to	513,776	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	110,692	equal to	110,692	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	4,538	equal to	4,538	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	111,143	equal to	111,143	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	10,824	< or = to	53,285	-42,461	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	10,824	equal to	10,824	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	6,267	equal to	6,635	-368	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-780,498	equal to	-780,498	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4l	B.	14	8
Total loan balance	7,612,650	equal to	7,612,650	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	126,000	equal to	126,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	495,000	equal to	495,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	6,706,910	equal to	6,706,910	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	688,348	equal to	688,348	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,720,250	equal to	1,720,250	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-821,505	equal to	-821,505	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	435,435	equal to	435,435	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	1,052	equal to	1,052	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,782,053	equal to	1,782,053	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1